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Commission to Evaluate the Effectiveness and Future of the Premium Assistance Program

September 6, 2017 Meeting

New Hampshire Health Protection Program NHHPP

SB 413 (2014)

- **Bridge Program** – Medicaid Managed Care Companies (8/30/2014-12/31/15)
- **Premium Assistance Program (PAP)** - Marketplace QHPS (1/1/2016-12/31/2016)

HB1696 (2016)

- Re-authorized **PAP** for an additional two years (2017 – 2018)
- Funded the "gap" as federal funds percentage diminished

Federal funding availability:

2014-2016- 100%
2017- 95%
2018- 94%
2019- 93%
2020- 90% →

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Medicaid Expansion (PAP) 2017-2018

Discussion over two year extension generated important questions and considerations:

- Was an extension of the program the right thing to do?
- Beyond improving health and creating security for the expansion enrollees, would the projected decline in uncompensated care relieve cost-shifting pressure on insurance premiums?
- If an extension was the right thing to do, how would the program shortfall be funded?
- Would federal funding be reliable in the ensuing years?

And, more specific questions, such as:

- If extended, could the program design be improved?
- Would CMS countenance work requirements, higher cost shares, etc.?

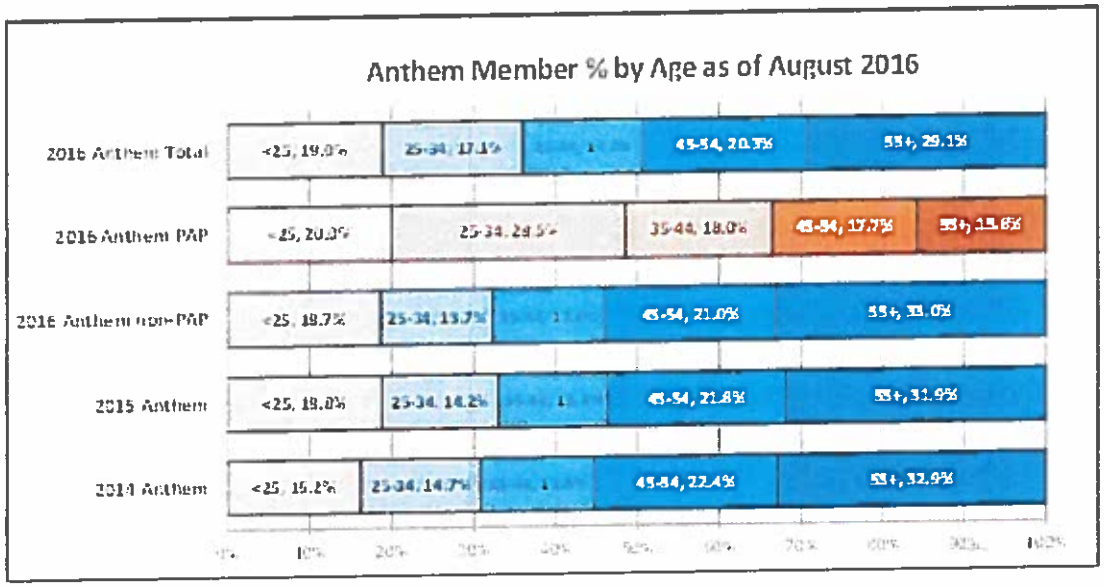
Premium Assistance Program (PAP)
Funding the "remainder amount" (2017-2018)

Addressing the federal funding shortfall over the two year extension:

- $11 Million - premium taxes generated by PAP enrollees
- $43 Million - "remainder amount" borne equally by plans / hospitals
- NH Health Plan- re-purposed to assess plans (all plans including ASO w/stop loss)
- 2017 plan assessments - $1.67 pmpm on "covered lives"
- 2018 assessment projections- just shy of $2.00 pmpm on "covered lives"
- Hospital Funding -"voluntary contributions" / impermissible after 2018 (CMS)

Note: remainder amount will increase (substantially)when federal funding drops to 90%

Anthem's Experience



	Average Age
non-PAP	42.9
PAP	37.9
Total	41.6

Major Differences:

- The average age of the PAP population is 5 years younger than non-PAP.
- This is significant because PAP members do not have any dependents on the plan. The average age is based only on subscriber age in PAP, whereas non-PAP includes children & spouses.
- Important because premium factor is age banded. So, we are receiving premium for an average age of 37 but claims are much higher than normal 37 year olds.

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Anthem's Experience

The key drivers of claims are the following services:

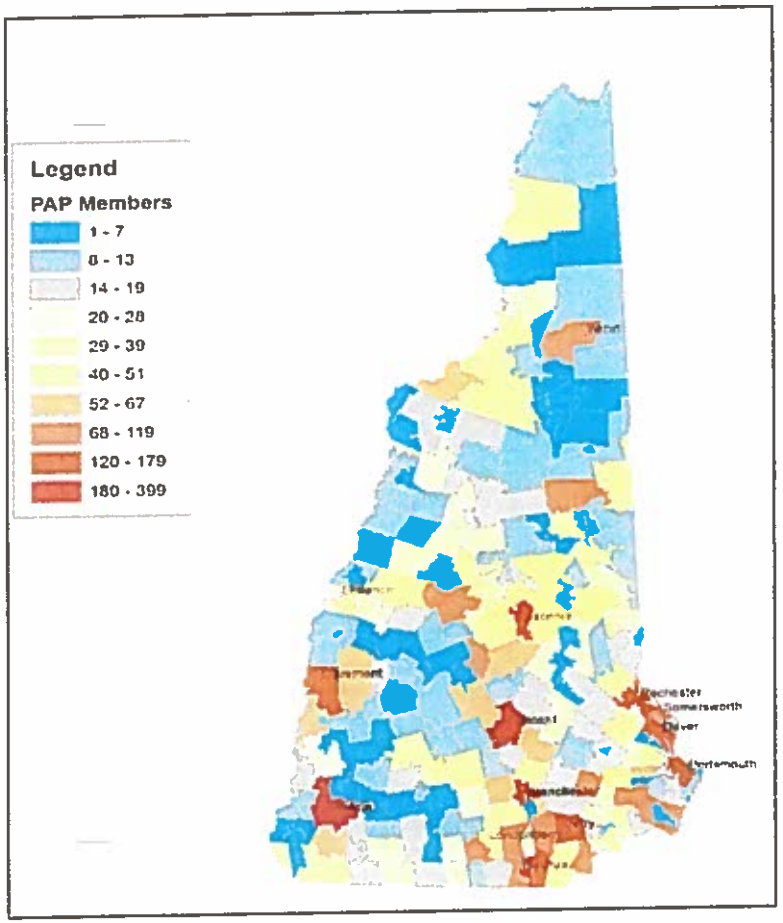
- **Emergency Room** – 2-3X higher PMPM than other CSR members – half were likely avoidable
- **Behavioral health and substance abuse** - more than 8-10X higher than other members.
- **Pharmacy** – brand drug PMPMs 17.5% higher than other CSR members; 79% higher than silver non-CSR members. (driven in some measure by hepatitis agents/opioid agonists)
- **Loss Ratio** - **120%** higher costs across all categories of care (IP, OP, PR and Rx)
- **PAP enrollees**- preventative care is lagging

That said, **PAP enrollees** have a higher percentage of members with **no claims**

PAP Rating Impacts

1. PAP claims costs are much higher than the Non-PAP, driving up the average claims cost in the market.

2. The rate impact may be compounded by anti-selection, as healthier unsubsidized IND ACA members drop coverage when premiums rise, further worsening the IND ACA risk pool.



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Administrative Concerns

Medical Frailty & Self Attestation

- Concerns with definition and requirement that member must self-attest to being medically frail

Eligibility Review /Churn

- We often see members enroll and disenroll due to eligibility issues

Lack of PCP Assignment at Enrollment

- PCPs are vital to ensuring appropriate care

Inability to Coordinate Care for Incarcerated Members

- Who is responsible for care during incarceration?

Inadequate/Inaccurate member contact information

Questions

1. Are the needs of these newly eligible enrollees better served in the commercial market or in a Medicaid program setting?

2. If enrollees are to remain in the Marketplace, what can be done to mitigate some of the adverse developments? Can there be some mitigation in the coming calendar year?

   - explore feasibility of plan design changes
   -consider separate rates/risk pools for PAP premiums
   -develop a collaborative process regarding the medically frail
   -require initial assignment of PCPs & transfer information in the 834 enrollments
   -consider increased cost shares or employment requirements for enrollees
   -collaborate/coordinate with DHHS on transportation programs

3. If the program were to continue in whatever setting, how can the funding issues be addressed?